State of Utah

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Date: March 15, 2022

Mr. Robert Hunter, Board Chair
Weber Human Services/ Weber County Commission
2380 Washington Blvd., #360
Ogden, UT 84401

Dear Mr. Hunter:

In accordance with Utah Code Annotated 62A-15-103, the Division of Substance Abuse and Mental Health has completed its annual review of the contracted Local Authority, Weber Human Services; the final report is enclosed. The scope of the review included fiscal management, children, youth, family and adult mental health services, substance abuse treatment and prevention services, and general operations.

The center has many strengths; however, this report by its nature focuses on the exceptions and areas in need of improvement. The Division has approved all corrective action plans submitted by the Center/County in response to each reported finding, which have been included in the final report. If you have any questions, please contact Kelly Ovard at 385-310-5118.

We appreciate the cooperation and assistance of the staff and look forward to a continued professional relationship.

Sincerely,

Brent Kelsey
Division Director

Enclosure
cc: Scott Jenkins, Weber County Commissioner
Matt Wilson, Morgan County Council
Kevin Eastman, Director, Weber Human Services

utah department of human services
SUBSTANCE ABUSE AND MENTAL HEALTH

Site Monitoring Report of

Weber Human Services

Local Authority Contract #A03084

Review Date: January 25th, 2022

Final Report

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Section One: Site Monitoring Report

Executive Summary

In accordance with Utah Code Section 62A-15-103, the Division of Substance Abuse and Mental Health (also referred to in this report as DSAMH or the Division) conducted a review of Weber Human Services (also referred to in this report as WHS or the Center) on January 25, 2022. The focus of the review was on governance and oversight, fiscal management, pediatric and adult mental health services, substance abuse prevention and treatment services and general operations.

The nature of this examination was to evaluate the Center's compliance with: State policies and procedures incorporated through the contracting process; Division Directives; State mandated mental health services; and Preferred Practice Guidelines. During the examination, the review teams evaluated: the reliability and integrity of the Center's data and its compliance with established programmatic and operational objectives. Additionally, the review included an examination, through sampling, of the Center's efficient and appropriate use of financial resources.

Any program or operational inadequacies are identified in this report as non-compliance issues. The chart on the following page provides a quick reference to locate any non-compliance issues identified by the monitoring team. A detailed description of the issues can be found in the body of this report.

Summary of Findings

Programs Reviewed	Level of Non-Compliance Issues	Number of Findings	Page(s)
Governance and Oversight	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	2	7-8
Child, Youth & Family Mental Health	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	None	
Adult Mental Health	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	None	
Substance Use Disorders Prevention	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	None	
Substance Use Disorders Treatment	Major Non-Compliance	None	
	Significant Non-Compliance	None	
	Minor Non-Compliance	None	
	Deficiency	1	19-20

Governance and Fiscal Oversight

The Division of Substance Abuse and Mental Health (DSAMH) conducted its annual monitoring review of the Local Authority, Weber Human Services (WHS). The Governance and Fiscal Oversight section of the review was conducted on January 25, 2022 by Kelly Ovard, Financial Services Auditor IV.

Due to current DSAMH policy, the audit was conducted remotely with WHS as the Local Mental Health Authority for Weber and Morgan Counties. Overall cost per client data was analyzed and compared to the statewide Local Authority average. Personnel and subcontractor files were examined for compliance with state licensing laws and adherence to contractual requirements, as well as the Center's own policy. Executive travel reimbursements were reviewed to ensure they were appropriate and that no personal benefit has been gained. Board minutes were reviewed and discussions were conducted to determine if an appropriate level of involvement and financial oversight was provided.

As part of the site visit, WHS provided backup to support their costs and billed amounts, using rates taken from their Medicaid Cost Report. This report is a cost study conducted by the Local Authority and then reviewed/approved by the Department of Health (DOH), Medicaid Division. This report establishes the center's cost allocation plan as it pertains to overhead/administrative costs and spreads these costs across the Current Procedural Terminology (CPT) billing codes used by the Center that year. This allows the Division to fairly incorporate these overhead/administrative costs into the payments sent for services that qualify for funding found on the Center's contract allocation letter. Random samples were taken from the backup provided to verify that the listed services qualified for each different service category.

As the Local Authority, WHS received a single audit as required. The CPA firm Christensen, Palmer & Ambrose completed the audit for the year ending June 30, 2020 The auditors issued an unmodified opinion in their report dated February 6, 2021. The SAPT Block Grant and the TANF Grant were selected for specific testing as a major program. There were no findings or deficiencies reported. (New Audit for YE June 30, 2021 expected anytime)

Follow-up from Fiscal Year 2021 Audit:

There were no findings from FY21.

Findings for Fiscal Year 2022 Audit:

FY22 Major Non-compliance Issues:
None

FY22 Significant Non-compliance Issues:
None

FY22 Minor Non-compliance Issues:
None

FY22 Deficiencies:

1) The **service code EBI for Evidence Based 1st Psychosis** was audited and verified with Kissflow. The Local Authorities have been providing billing backup for this code. Weber has struggled in tracking the individual services in this area for clients 15-25 years old. Services include anything under a Coordinated Specialty Care continuum including therapy, case management, med management, peer support services. Services were provided but not equal to the amount paid to WHS by DSAMH. WHS provided a total nearly 3x the amount billed to DSAMH for this code, but were used for salaries and expenses approved in Kissflow. EBI will need to be tracked by service for the FY23 audit.

County's Response and Corrective Action Plan:

Action Plan:
WHS is implementing strategies to better identify clients that qualify for this service. We are doing this by having our Adult and Youth teams refer all clients that meet the criteria to the primary therapist for a screening. The therapist will then enroll the clients that can benefit from this service into the program. We believe that this will help us track all of the services being provided under this grant more accurately. In the event we are not able to enroll enough clients, we would bill less money for this service.

Timeline for compliance: March 1, 2022 reviewing services back to 7/1/2021

Person responsible for action plan: Nathan Piggott

Tracked at DSAMH by: Kelly Ovard

2) There was tracking of the **subcontractors** using CPT checklists each month if the subcontractor provided a service. A general overview of the audit was provided, but the CPT checklist was not saved. Next year the LA will be required to provide details and a summary of the audit performed. Technical Assistance is available to WHS to complete this in a timely manner. It is suggested that all subcontractor audits for WHS going forward use the CPT checklist as an outline for the audit and save all subcontractor audits and provide for next year's audit.

County's Response and Corrective Action Plan:

Action Plan: WHS currently uses the Medicaid provider manual record requirements to review specific CPT coded services. We will be creating a specific checklist that reflects these requirements, and use it to document the review that was done for each provider. The services will be taken from an invoice submitted by the subcontractor to review for compliance.

Timeline for compliance: March 1, 2022

Person responsible for action plan: Nathan Piggott

Tracked at DSAMH by: Kelly Ovard

FY22 Recommendations:

1) **The WHS emergency plan** (WHS Contract 2.4) was reviewed by Nichole Cunha, Program Administrator II and Geri Jardine, Program Support Specialist, as part of monitoring. A checklist based on SAMHSA recommendations was completed and is included at the end of this report as Attachment A. It is recommended that WHS review these suggestions and update their emergency plan accordingly. In review of last year's tool, the areas remarked as non-compliant resulted in recommendations not addressed. **In discussion with Kim Myers, Nichole Cunha and Geri Jardine, you will have a 90-day window to resolve non-compliant areas. Should the non-compliance not be resolved, at that time, a finding would be issued**. We would like to emphasize that Technical Assistance is available to the WHS team during this time. We are here to support and develop a plan with their team. **Please resolve by 6/10/22. (See Attachment A at the end of this report.)**
2) **I9's**: There were 2 I9's where the hire date was missing. There was one I9 where the HR office signed and verified the I9 26 days after the hire date. The federal requirement is to have the HR sign the document before hire but no later than 3 working days after the hire date.

FY22 Division Comments:

1) Please note **FY22 Division Directive data and upload requirements:** Section A viii. For each site visit, random client numbers shall be provided by the DSAMH for chart review. Additional charts may be requested by the monitoring teams to be pulled by the LA for specific populations or areas of concern. The LA shall provide the monitoring team electronic remote access to the selected charts **three weeks** prior to the audit date

and all other documents requested by DSAMH at least **two weeks** before the site visit, including passwords and instructions needed to access the files in their electronic health record needed for timely remote access by DSAMH staff. **Failure to provide this information within the required timeframe will result in a warning from DSAMH for the FY22 audit. If data was delayed in the FY22 audit, it could warrant a finding for FY23**. LAs shall provide internal chart reviews for the two years prior to the current monitoring year. DSAMH will comply with HIPAA, 42 CFR and all other applicable records review requirements.

Mental Health Mandated Services

According to Utah Code 17-43-301, the Local Authority is required to provide the following ten mandated services:

Inpatient Care
Residential Care
Outpatient Care
24-hour Emergency Services
Psychotropic Medication Management
Psychosocial Rehabilitation (including vocational training and skills development)
Case Management
Community Supports (including in-home services, housing, family support services, and respite services)
Consultation and Education Services
Services to persons incarcerated in a county jail or other county correctional facility

The mandate to provide services to those in county correctional facilities is not applicable to the children and youth population.

In subsection (4)(a)(ii) each local authority is required to "annually prepare and submit to the Division a plan approved by the county legislative body for mental health funding and service delivery, either directly by the local mental health authority or by contract." This annual area plan provides the state Division of Substance Abuse and Mental Health with a measuring tool against which the local authority is measured during the annual monitoring site review.

A major focus of the monitoring efforts of the Division of Substance Abuse and Mental Health is to measure compliance with this legislative mandate to provide these services to the adults, youth, and children of Utah.

Combined Mental Health Programs

The Division of Substance Abuse and Mental Health (DSAMH) Mental Health Team conducted its annual monitoring review at Weber Human Services (WHS) on January 25, 2022. Due to the current DSAMH policy, the annual monitoring review was held virtually. Duplicate recommendations and comments for Child, Youth and Family and Adult Mental Health have been combined below to provide clarity and avoid redundancy.

FY22 Division Comments:

1) **Prevention and Recovery from Early Psychosis (PREP)***:* Weber has a very robust PREP program. They have a team that strives to help the community and identify early psychosis. They are able to get referrals for treatment from various community agencies. These include, but not limited to, hospitals, schools and direct referrals.

2) **Cultural Responsivity:** DSAMH commends WHS for efforts to create an inclusive treatment environment. WHS demonstrated notably LGBTQ+ friendly public spaces, Black, Indigenous, and People of Color-inclusive public-facing documents, and a youth-friendly environment with useful pamphlets and materials. Leadership from WHS demonstrated a philosophy of wanting to provide equitable and accessible culturally-appropriate services for the racial and ethnic minorities they serve.

3) **Clinical Documentation:** WHS as evidenced through the chart review process has strong documentation in both the youth and adult charts. DSAMH highlights the consistency in the administration and use as an intervention in the Outcome Questionnaire/Youth Outcome Questionnaire. WHS clinical documentation highlights their commitment to best practice standards to driving quality care and strong clinical outcomes.

Child, Youth and Family Mental Health

The Division of Substance Abuse and Mental Health Children, Youth, & Families team conducted its annual monitoring review at Weber Human Services (WHS) on January 25, 2022. Due to current DSAMH policy, the annual monitoring review was held virtually. The monitoring team consisted of Leah Colburn, Program Administrator; Mindy Leonard, Program Manager; Tracy Johnson, Wraparound and Family Peer Support Program Administrator; and Heather Rydalch, Peer Support Program Manager. The review included the following areas: discussions with clinical supervisors and management, record reviews, program visits, and allied agency visits. During the discussion the team reviewed the FY21 audit, statistics, including the Mental Health Scorecard, Area Plans, Youth Outcome Questionnaires, Family Resource Facilitation (Peer Support), High Fidelity Wraparound, school based behavioral health and compliance with Division Directives and the center's provision of the ten mandated services as required by Utah Code 17-43-301.

Follow-up from Fiscal Year 2021 Audit

FY21 Deficiencies:

1) **Suicide Risk Assessment:** In the chart review, two of ten were identified as not having a CSSRS completed and revisited when suicide risk was identified. One chart did have a thorough safety plan completed. While WHS has implemented a process within their EHR to prompt clinicians to complete a CSSRS and safety plan stemming from the outcome of the YOQ, this will be a deficiency due to risk to the client. It is recommended that WHS review with clinical teams the process for CSSRS/Safety Planning. DSAMH encourages the WHS to seek technical assistance as needed surrounding administration of CSSRS in clinical settings for children and youth.

   This item has been resolved and will not be a finding in 2022.

Findings for Fiscal Year 2022 Audit:

FY22 Major Non-compliance Issues:

None

FY22 Significant Non-compliance Issues:

None

FY22 Minor Non-compliance Issues:

None

FY22 Deficiencies:

None

FY22 Recommendations:

1) **Respite Services**: Per the FY21 scorecard, WHS has provided respite services at a lower rate than the urban average (FY20/ 0.1% to FY21/0.5%). WHS reported they are focused on increasing respite through group and individual services. It is recommended that WHS continue to expand access to respite, and encourage their clinical teams to utilize respite as an early intervention for youth and families who are engaged in treatment services.

2) **Case Management:** The FY21 scorecard shows that while increasing from the prior year, this service is provided lower than the urban average for the second year. (FY21 WHS/4.1% Urban/26.5%). It is recommended that WHS continue to seek to increase case management services. Case management can be a key service to support the family system in reducing barriers in their lives to support sustained recovery.

FY22 Division Comments:

1) **Family Peer Support:** WHS has a deep understanding of the importance of Family Peer Support Services (FPSS) and its role as part of the continuum of care to support youth and families in symptom reduction. WHS had a large decrease of 60 families served from FY20 to FY21. WHS reports this decrease is due to a decrease in FPSS staff and changes in documentation for families served who are not active WHS clients. WHS is actively working to increase FPSS staffing. It is encouraged that WHS continue to prioritize access to FPSS for families as part of their continuum. WHS is also encouraged to continue to work with DSAMH as FPSS needs arise.

2) **Pediatric Integrated Care:** WHS has begun to pilot an integrated care program with Intermountain to support early intervention behavioral health access in a pediatric primary care setting. WHS and the Intermountain clinic have worked to develop referral pathways to support ease of access to care for youth and their families. WHS reports that in the first few months of this program, there has been a high referral rate from the pediatricians in the clinic, which WHS believes speaks to the need for this access point for services in the community. DSAMH commends WHS for the decision to explore and begin this pilot as an alternative to traditional referral sources in their community.

Adult Mental Health

The Division of Substance Abuse and Mental Health Adult Mental Health team conducted its annual monitoring review at Weber Human Services (WHS) on January 25, 2022. Due to current DSAMH policy, the annual monitoring review was held virtually. The monitoring team consisted of Mindy Leonard, Program Manager; Leah Colburn, Program Administrator; Pam Bennett, Program Administrator; and Heather Rydalch, Peer Support Program Manager. The review included the following areas: discussions with clinical supervisors and management, record reviews, clinical staffing and a community meeting. During the discussion the team reviewed the FY21 audit statistics, including the Mental Health Scorecard, Area Plans, Outcome Questionnaires, compliance with Division Directives and the center's provision of the ten mandated services as required by Utah Code 17-43-301.

Follow-up from Fiscal Year 2021 Audit:

There were no findings from FY21.

Findings for Fiscal Year 2022 Audit:

FY22 Major Non-compliance Issues:
None

FY22 Significant Non-compliance Issues:
None

FY22 Minor Non-compliance Issues:
None

FY22 Deficiencies:
None

FY22 Recommendations:

1) **Case Management Services:** The FY21 DSAMH Adult Mental Health scorecard indicates that case management services continued to decrease in FY21 (FY19-25.6%; FY20-24.4%; FY21-20.7%). This continues to be a significantly lower rate than the urban average (WHS-20.7%; urban average-45.1%). Although many services have declined due to the pandemic, this trend is concerning. DSAMH recommends that WHS continue to develop opportunities to increase access to case management services.

FY22 Division Comments:

1) **OQ Evidence of Client Recovery:** Data from the FY21 DSAMH Adult Mental Health scorecard demonstrates that WHS continues to have the lowest percentage of individuals with serious mental illness who report that they have not recovered on discharge, when compared across the Local Authorities (8.49%). Outcomes support the decision that

WHS has made to focus on evidence-based practices and a strong supervision model to work with clients toward recovery.

2) **Addressing Barriers to Client Care:** WHS has addressed increasing client numbers and fewer staff available in a number of ways. This includes development of specialty clinics for evidence-based programs. WHS has also created a clinical contract template for each client. This outlines what to expect including longevity of services and responsibilities that the client has in their care and treatment.

3) **Peer Support Services:** Heather Rydalch, Peer Support Program Manager, met with four Certified Peer Support Specialists (CPSS) and a supervisor. When the office was shut down due to the pandemic, the CPSS adjusted so that groups could be held using a telehealth platform. They provided meals and outreach, and coordinated with the local food bank to assist with delivering food boxes to some of the clients. CPSS groups are now held both in person and virtually. "*Some clients do not feel comfortable coming in and the Peers have been very good at directing clients … so they can connect for services.*"
WHS had a decrease of 43 adult clients served from FY20 to FY21. WHS indicated that there have been some barriers to hiring CPSS in the past. This has included the applicant pool not meeting the criteria of the job, which they felt may be due to how the job description was written. However, the CPSS adult team is now fully staffed.

4) **Participant Feedback:** Heather Rydalch, Peer Support Program Manager, met with four individuals who have a range of experience working with WHS (from two months to twelve years). Participants emphasized that the connection to others is important to them. One participant said "*I have been coming for over 10 years. I have had a few bumps in my life and this has been helpful for me. Peer Support helps me move forward, it really made a difference. I am not alone anymore".* Another person commented, "*so much has changed for me. I used to be very depressed, having friends has really helped me.*" Individuals also expressed appreciation for assistance with housing and work - "*I used to be homeless and now I live in temporary housing and I am working on getting my own apartment*" and "*I work in the kitchen, I love it and I love this place! I am staying out of trouble. I am a happier person."*

Substance Use Disorders Prevention

Becky King, Program Administrator, conducted the annual prevention review of Weber Human Services on January 25, 2022. The review focused on the requirements found in State and Federal law, Division Directives and contracts. In addition, the review evaluated the services described in the annual prevention area plan and the data used to establish prevention priorities.

Follow-up from Fiscal Year 2021 Audit

FY21 Deficiencies:

1) The number of Eliminating Alcohol Sales to Youth (EASY) Compliance checks decreased from 171 to 56 from FY19 to FY20 respectively, which does not meet Division Directives. Local Authorities are required to increase their EASY Compliance checks by at least one each year.

The number of Eliminating Alcohol Sales to Youth (EASY) Compliance checks decreased from 56 to 33 from FY20 to FY21 respectively, which does not meet Division Directives. Local Authorities are required to increase their EASY Compliance checks by at least one each year.

This issue has not been resolved, which will be addressed with Recommendation #1 below.

Findings for Fiscal Year 2022 Audit:

FY22 Major Non-compliance Issues:
None

FY22 Significant Non-compliance Issues:
None

FY22 Minor Non-compliance Issues:
None

FY22 Deficiencies:
None

FY22 Recommendations:

1) **Easy Compliance Checks:** The number of Eliminating Alcohol Sales to Youth (EASY) Compliance checks decreased from 56 to 33 from FY20 to FY21 respectively, which does not meet Division Directives. Local Authorities are required to increase their EASY Compliance checks by at least one each year.

FY22 Division Comments

1) **Coalitions:** WHS oversees four coalitions: Bonneville Communities that Care (CTC), Roy CTC, Weber CTC, and Fremont 5 CTC. They are also in conversations with Project Success (a coalition serving persons of color) to integrate CTC into their existing coalition. The Roy Communities that Care (CTC) Roy CTC, Weber CTC, Fremont 5 CTC, and Bonneville CTC are each going through Phase 5 of the CTC process, and are preparing to go back through phase 2/3 to redo their assessments. They are each re-examining the Milestones and Benchmarks to ensure that any challenges are addressed and capacity is increased. WHS and the coalitions are always seeking ways to support their partners on implementing evidence based practices in their community, reduce risk factors and increase protective factors.

2) **Community Partnerships:** WHS has increased community partnerships with local coalitions, and have been partnering with them to meet the needs of their community. They evaluate the implementation of programs for fidelity, and throughout the process, to ensure that programs are meeting the needs of the community. WHS is working to sustain the programs by continuing to seek funding opportunities and promoting prevention strategies.

3) **Program Sustainability:** WHS cooperates with each coalition to support them in seeking out funding for their coalition. Some of the coalitions have applied for and received funding from various grants (Prevention Strategic Framework (PFS) Grant from DSAMH, and e-Cigarette funds from the local Health Department). Some coalitions have funding provided by their cities, while others are still looking to get that buy-in from their local governments. WHS also partners with other agencies and organizations to meet the needs of the community, including promoting each other's programs, sharing data, or serving on committees to have a prevention voice at the table. WHS works with the coalitions to sustain programs by continuing to seek funding opportunities, promoting prevention strategies and matching funds for grants received by coalitions.

Substance Use Disorder Treatment

Becky King, Program Administrator, conducted the review of Weber Human Services on January 26, 2022. The review focused on Substance Abuse Treatment (SAPT) Block Grant Compliance, Drug Court compliance, clinical practice and compliance with contract requirements. Clinical practices and documentation were evaluated by reviewing client charts and discussing current practices. Adherence to SAPT Block Grant requirements and contract requirements were evaluated by a review of policies and procedures, discussion with WHS staff and a review of program schedules and other documentation. WHS performance was evaluated using Utah Substance Abuse Treatment Data Dashboard and Consumer Satisfaction Survey data. Client satisfaction was measured by reviewing records and the Consumer Satisfaction Survey data.

FY21 Minor Non-compliance Issues:

1) The Substance Use Disorder Treatment Outcomes Scorecard shows the following outcomes which do not meet Division Directives:

a) The percent of clients that decreased tobacco use from admission to discharge moved from -0.6% to 0.7% from FY19 to FY20 respectively.

The percent of clients that decreased tobacco use from admission to discharge moved from 0.7% to 0.4% from FY20 to FY21 respectively, which does not meet Division Directives.

This issue is not resolved, which will be addressed in Recommendation #1(a) below.

b) The percent increase in stable housing for non-homeless clients from admission to discharge decreased from 1.9% to 1.0% from FY19 to FY20 respectively.

The percent increase in stable housing for non-homeless clients from admission to discharge moved from 11.4% to -7.0% from FY20 to FY21 respectively, which meets Division Directives.

This issue has been resolved.

c) The percent increase in those using social recovery supports moved from 6.7% to 11.4% from FY19 to FY20 respectively.

The percent increase in those using social recovery supports moved from 11.4% to -7.0% from FY20 to FY21 respectively, which does not meet Division Directives.

This issue is not resolved, which will be addressed in Recommendation #1(b) below.

2) The Consumer Satisfaction Survey shows that the percent of Youth (Family) that were sampled was 6.0%, which does not meet Division Directives.

The Consumer Satisfaction Survey shows that the percent of Youth (Family) that were sampled was 2.1%, which does not meet Division Directives.

This issue is not resolved, which will be addressed in Minor Non-Compliance #1(a) below.

FY21 Deficiencies:

1) The TEDS data shows that 17.6% of the data was reported as unknown and 16.5% was uncollected for Criminogenic Risk for justice involved adults, which does not meet Division Directives.

The TEDS data shows that 2.1% of the data was reported as unknown and 3.4% was uncollected for Criminogenic Risk for justice involved adults, which meets Division Directives.

This issue has been resolved.

<u>Findings for Fiscal Year 2022 Audit:</u>

FY22 Major Non-compliance Issues:
None

FY22 Significant Non-compliance Issues:
None

FY22 Minor Non-compliance Issues:

1) The Consumer Satisfaction Survey shows:
    a) The percent of **Youth (Family)** that were sampled was 2.1% in the FY21, which does not meet Division Directives.
    b) The percent of **Youth** that were sampled was 1.2% in the FY21, which does not meet Division Directives.
    c) The percent of **Adults** that were sampled was 5.0% in the FY21, which does not meet Division Directives.

County's Response and Corrective Action Plan:

Action Plan:
We were informed that we wouldn't be held accountable for meeting minimum requirements for the Consumer Satisfaction Surveys during COVID. We had emailed the survey multiple times to consumers to complete as we were not meeting in person with consumers during the time the

survey was conducted. For this year, consumers are able to access services in person or through telehealth. Surveys will be conducted in person prior to or upon completion of a scheduled appointment.

Timeline for compliance:
Surveys will be completed during the 3rd quarter of FY22.

Person responsible for action plan: Wendi Davis-Cox

Tracked at DSAMH by: Becky King

FY22 Recommendations:

1) **Teds Data** shows that:
    a) The percent of clients that decreased **tobacco use** from admission to discharge moved from 0.7% to 0.4% from FY20 to FY21 respectively, which does not meet Division Directives.
    b) The percent increase in those using **social recovery support** moved from 11.4% to -7.0% from FY20 to FY21 respectively.

2) **Assessment:** The Initial Assessment does not have a question related to whether the client is interested in receiving Medication Assisted Treatment (MAT) for tobacco or opioid use if indicated. It is recommended that this question be added to the assessment.

FY22 Division Comments:

1) **Trauma-Informed Approach:** WHS has contracted with Gabriella Grant, Director of the California Center of Excellence for Trauma-Informed Care to provide assessment, training and consultation on the Trauma-Informed Approach for their agency. A Trauma-Informed Approach responds to those who have experienced trauma or may be at risk for experiencing trauma. A program, organization or system that is Trauma-Informed (1) **realizes** the prevalence of trauma and taking a universal precautions approach (2) **recognizes** how trauma affects all individuals involved with the program, organization, or system, including its own workforce (3) **responds** by putting this knowledge into practice and (4) **resists** retraumatization. In the first year of this contract, WHS has focused on assessing their residential programs, including Tranquility Home Women and Children's Residential Treatment and Stepping Stones Men's Residential Treatment. WHS has signed another contract with Gabriella Grant to provide consultation on their agency policies and documents so that they are more client friendly.

2) **Recovery Housing / Sober Living:** WHS located a building in Pleasant View to set up recovery housing. The model they will be using for recovery housing will be for individuals and families which will have a capacity for 40 people. WHS is currently in the process of pursuing funds for purchase of the building for the recovery housing,

which is located on 11 acres of land. Residents of the recovery housing program will be included in the Crown Program, where they will have an opportunity to purchase the home they are living at once they are discharged from recovery housing. WHS is exploring partnership with Utah Support Advocates for Recovery Awareness (USARA) to provide peer support / case management services for residents of their recovery housing program. The Pleasant View City Mayor and Council has been involved in planning efforts for the recovery housing program.

3) **LYSNN Program:** WHS has partnered with the Lysnn Program at the University of Utah on data collection for their evidence-based programs. This program is using artificial intelligence for recording and scoring sessions for clinicians that are using Motivational Interviewing in their therapy sessions. The University of Utah has been recording these sessions for WHS and other organizations across the nation for a while. Information from these recordings have shown that WHS is at a much higher rate of efficacy than other programs across the nation. WHS shared that they have focused on using Motivational Interviewing since they believe that engagement is one of the most important factors in promoting success for their clients.

Section Two: Report Information

Background

Utah Code Section 62A-15-103 outlines duties of the Division of Substance Abuse and Mental Health. Paragraph (2)(c) states that the Division shall:

- Consult and coordinate with local substance abuse authorities and local mental health authorities regarding programs and services,
- Provide consultation and other assistance to public and private agencies and groups working on substance abuse and mental health issues,
- Receive, distribute, and provide direction over public funds for substance abuse and mental health services,
- Monitor and evaluate programs provided by local substance abuse authorities and mental health authorities,
- Examine expenditures of any local, state and federal funds,
- Monitor the expenditure of public funds by local substance abuse authorities and mental health authorities,
- Contract with local substance abuse authorities and mental health authorities to provide a continuum of services in accordance with division policy, contract provisions, and the local plan,
- Assure that these requirements are met and applied uniformly by local substance abuse authorities and mental health authorities across the state,
- Conduct an annual program audit and review of each local substance abuse authority and mental health authority in the state and its contract provider in a review and determination that public funds allocated to by local substance abuse authorities and mental health authorities are consistent with services rendered and outcomes reported by them or their contract providers,
- Each local substance abuse authority and each mental health authority is exercising sufficient oversight and control over public funds allocated for substance abuse and mental health programs and services, and
- Other items determined by the division to be necessary and appropriate.

Non-Compliance Issues, Action Plans and Timelines

This report is organized into individual sections, in which inadequacies will be identified and discussed. Inadequacies are assigned a level of severity based on the combined judgment of the monitoring team. In order to fully understand the degree of severity, a short discussion of the inadequacy levels follows.

A **major non-compliance issue** is non-compliance in contract requirements which affect the imminent health, safety, or well-being of individuals. In cases of non-compliance at this level, a written corrective action plan must be completed by the Local Authority immediately and compliance must be achieved within 24 hours or less.

It should be noted that in extreme cases where, in the professional opinion of the monitoring team, an elevated threat of imminent health, safety, or well-being of individuals exists, contract payments may be suspended indefinitely.

A **significant non-compliance issue** is either 1) non-compliance with contract requirements that do not pose an imminent danger to clients but that result in inadequate treatment or care that jeopardizes the well-being of individuals; OR 2) non-compliance in required training, paperwork, and/or documentation that are so severe or pervasive as to jeopardize the effectiveness of services and continued contract funding. This type of finding will also require the submission of a written corrective action plan in which the Local Authority identifies the steps it will take to rectify the issue and a time frame for accomplishing the correction. The due date for this submission shall be within **10 working days** of receipt of the draft monitoring report by the Local Authority. Compliance must be achieved within 30 days of receipt of the draft monitoring report. Verification of the resolution may be accomplished in several ways including a follow-up visit, measurement during the next site review, a review of training documentation, a review of data submitted subsequent to the correction or a combination of these or any other method determined adequate to measure the resolution.

A **minor non-compliance issue** results when the reviewers identify a performance inadequacy that is relatively small in scope and does not impact client well-being or jeopardize funding. This type of finding will require the submission of a written corrective action plan in which the Local Authority identifies the steps it will take to rectify the issue and a time frame for accomplishing the correction. The due date for this submission shall be within **15 working days** of receipt of the draft monitoring report by the Local Authority. Compliance must be achieved within 60 days of receipt of the draft monitoring report. Verification of the resolution may be accomplished in several ways including a follow-up visit, measurement during the next site review, a review of training documentation, a review of data submitted subsequent to the correction or a combination of these or any other method determined adequate to measure the resolution.

A **deficiency** results when the contractor is not in full compliance, but the deficiency discovered is not severe enough to be categorized as a non-compliance issue. A written corrective action

plan is required without a formal timeline. However, the monitoring team may request action to fix the problem by a given date.
A **recommendation** occurs when the contractor is in compliance. The Division is simply making a best practice or technical suggestion. The contractor is encouraged to implement the suggestion but not required.

In rare instances, a non-compliance issue from a previous year may continue unresolved at the time of the monitoring site visit. A recurring non-compliance issue will be prominently displayed in the current monitoring report and will require special attention by the Local Authority to ensure its immediate resolution.

Signature Page

We appreciate the cooperation afforded the Division monitoring teams by the management, staff and other affiliated personnel of Weber Human Services and for the professional manner in which they participated in this review.

If there are any questions regarding this report please contact Kelly Ovard at 385-310-5118.

The Division of Substance Abuse and Mental Health

Prepared by:

Kelly Ovard Kelly Jay Ovard Date 03/15/2022
Administrative Services Auditor IV

Approved by:

Kyle Larson Kyle Larson Date 03/15/2022
Administrative Services Director

Kimberly Myers Kim Myers Date 03/15/2022
Assistant Director Mental Health

Eric Tadehara Date 03/15/2022
Assistant Director

Brent Kelsey Date 03/15/2022
Division Director

Attachment A

UTAH DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

Emergency Plan Monitoring Tool FY22

Name of Local Authority: **Weber Human Services**

Date: **01/18/22**

Reviewed by: **Nichole Cunha, LCSW, Program Administrator**
Geri Jardine, Program Manager

Compliance Ratings
Y = Yes, the Contractor is in compliance with the requirements.
P = Partial, the Contractor is in partial compliance with requirements; comments provided as a suggestion to bring into compliance.
N = No, the Contractor is not in compliance with the requirements.

Monitoring Activity	Compliance			Comments
	Y	P	N	
Preface				
Cover page (title, date, and facility covered by the plan)		X		Need to have date on the plan
Confirmation of the plan's official status (i.e., signature page, date approved)			X	Need to have a signature page or confirmation of official status
Record of changes (indicating dates that reviews/revisions are scheduled/have been made and to which components of the plan)		X		Need to have dates of revision(s) and indication of changes with dates of changes
Method of distribution to appropriate parties (i.e. employees, members of the board, etc.)			X	Need to have a distribution list
Table of contents	X			
Basic Plan				
Statement of purpose and objectives	X			
Summary information	X			
Planning assumptions	X			
Conditions under which the plan will be activated	X			
Procedures for activating the plan	X			
Methods and schedules for updating the plan, communicating changes to staff, and training staff on the plan	X			
Functional Annex: The Continuity of Operations (COOP) Plan to continue to operate during short-term or long-term emergencies, periods of declared pandemic, or other disruptions of normal business.				
List of essential functions and essential staff positions			X	Need to identify specific positions and essential staff
Identify continuity of leadership and orders of succession			X	Need to identify specific names and numbers (i.e., attach an org chart and telephone/cell phone numbers, etc.)
Identify leadership for incident response		X		Need to identify specific name for incident response (i.e., attach an org chart)

List alternative facilities (including the address of and directions/mileage to each)	X			
Communication procedures with staff, clients' families, the State and community			X	Need to identify coordination efforts with the State, community, and clients' families.
Procedures that ensure the timely discharge of financial obligations, including payroll.			X	Need to address procedures to ensure the timely discharge of financial obligations, including payroll.
Planning Step				
Disaster planning team has been selected, to include all areas (i.e., safe/security, clinical services, medication management, counseling/case management, public relations, staff training/orientation, compliance, operations management, engineering, housekeeping, food services, pharmacy services, transportation, purchasing/contracts, medical records, computer hardware/software, human resources, billing, corporate compliance, etc.)			X	Need to identify who is on the disaster planning team and representing which area
The planning team has identified requirements for disaster planning for Residential/Housing services including: ● Engineering maintenance ● Housekeeping services ● Food services ● Pharmacy services ● Transportation services ● Medical records (recovery and maintenance) ● Evacuation procedures ● Isolation/Quarantine procedures ● Maintenance of required staffing ratios ● Address both leave for and the recall of employees unable to work for extended periods due to illness during periods of declared pandemic		X		Need to specify how these functions will be provided in the event of a disaster for Residential/Housing: ● Engineering maintenance ● Housekeeping services ● Food services ● Transportation services ● Medical records (recovery and maintenance) ● Isolation/Quarantine procedures ● Maintenance of required staffing ratios ● Address both leave for and the recall of employees unable to work for extended periods due to illness during periods of declared pandemic

DSAMH is happy to provide technical assistance.

DSAMH Weber Human Services FY22 Final Report

Final Audit Report 2022-03-16

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